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## CHAPTER EIGHT

### GOVERNING THE BODY: THE LEGAL, ADMINISTRATIVE AND DISCURSIVE CONTROL OF THE PSYCHIATRIC PATIENT

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Whilst much of our life-span may appear domestic in nature, occasionally our lives are punctuated with either the direct experience of, or presentation of imagery that highlights dramatic, unusual and potentially harmful activities or behaviours. In fact, our individual risk of harm is likely to be much greater than one necessarily assumes on a day-to-day basis, for example, travelling in a motor vehicle or eating a high calorie meal. Yet the rational construction of these risks are undertaken on a frequent, almost continuous basis and as individuals we develop our own frameworks of logic that make judgments over the benefits and potential harms of participating in a particular activity.

These lay judgments of risk are a naturally occurring phenomenon, but are shaped by an individual's understanding of what that particular risk may be. Lay judgments are often influenced by professional and scientific knowledge in addition to personal experience and influence from key institutions such as the media, government officials and experts. The virtues of avoiding a set of circumstances or altering behaviours that minimises potential harms are propounded and often can be observed to have legislative underpinnings (for example, public tobacco smoking restrictions in England and seat belt enforcement for motor vehicles). Enforcement strategies such as these govern a majority in society and may be intrinsic elements of agendas and discourses such as health promotion and health and safety. Such approaches to risk management have quickly become part of the cultural make-up of society, understandable of course in the context of a humanitarian concern for the health of society and public safety.

Mitigating risk is nothing new, and one particular area of risk management that has evolved has been in the area of crime control and the minimisation of harm to the public. A preventative logic has pervaded many institutions responsible for providing public protection. Of course, there have been failures and reviews of such failures have strengthened the resolve of specific institutions to think differently about their chosen approach. Criminal justice has not been alone in its attempts to mitigate the risks of criminality in society, rather psychiatry as a profession has had a key function in this process too. A medico-legal alignment has characterised an abundance of approaches to the social deviant, for example, the rise of forensic psychiatry and the physical presence of institutions designed specifically for the mentally disordered who have committed criminal offences or are deemed at risk of doing so (Mercer and Mason, 1998).

Psychiatry's function of preventing harm to others is just part of their mandate; it must also be acknowledged that it serves to prevent harm to the person themselves. Several scholars (see Kjellin and Nilstun, 2007 for an overview of the literature in this area) have termed this as medical paternalism, a process whereby the liberties of the individual are restricted so that medical interventions can be administered. This process takes place largely under the auspices of welfare and can frequently involve coercion and physical

restrictions being placed on the body (such as hospital detention under the Mental Health Act 1983 amended 2007). Whilst such approaches may be regarded as motivated by therapeutic concern this outlook may not be shared by those individuals who are subject of its interventions (Breeze, 1998). The justifications for limiting individual liberty therefore come under scrutiny, however, aggregated medical knowledge, coupled with official systems such as the Mental Health Act, serve to shape understandings of appropriate and inappropriate social conduct.

Libertarian, John Stuart Mill's (1859) *On Liberty* provides some illumination that for the state, or one of its agencies to become involved in prohibiting behaviours they must maintain a cautious approach. Mill's (1859) *Harm Principle* adopts a stance whereby self-regarding actions (actions which may only impact on the individual themselves) should not be interfered with. Mill positions this statement within a framework of responsibility, suggesting that social actors can free themselves from coercion of society or the state, only through a process whereby they become responsible and accountable for their actions. The outcomes for those who are consistently sanctioned by authority structures and legislation, in the view of Mill, are potentially grave, causing a situation whereby individuals 'neither obtain their fair share of happiness, nor grow up to the mental, moral, and aesthetic stature of which their nature is capable' (Mill, 1869 cited in D'Agostino, 1982, p. 319). For the psychiatric patient, the issue of responsibility is complex, as psychiatric knowledge has the capability to assert and suggest that individuals falling under particular diagnostic criteria may lack mental capacity, cannot make 'informed decisions' or in the judicial process, may be convicted of an offence on the grounds of 'diminished responsibility'.

Scholars emerging from the 'anti' and 'critical' psychiatry perspectives would argue that the coercive capabilities of the profession (for example, restrictions and controls over the body, mind and behaviours) take place under a veil of welfare and humanitarian concern. A discursive wrangling thus ensues with competing perspectives on the limits of legitimate state intervention to control the lives of others. Psychiatry's main opponents conceive that there is an over-use of preventative strategies. In these circumstances, the actual harm is not easily identifiable, neither is the victim (either self or others). The coercive and preventative approach that psychiatry readily uses, from a critical standpoint, does not emulate a liberal axiom of tolerance that Mill's original theorisations would support (see Levenson, 1986 for further ethical analyses of this).

Paternalism that is exercised by the state and its institutions takes place on many fronts and the author acknowledges that clinicians and practitioners undertake their work in the context of professional judgments and decision-making based on their individual and collective expertise. Furthermore, it is not the intention here to undermine the valuable work of the psychiatric profession, what this chapter aims to highlight is the significance of psychiatry's role in social control and participation in defining discourses and the meaning of risk.

### *The Politics of Risk and Risk Management*

The way in which risk is imagined is fluid and dynamic and there is a prevailing cultural preoccupation with its management in what has been coined broadly as the 'risk society' (Beck, 1992; Giddens, 1999). Insurances against risk are commonplace and take a variety of forms, for example, the welfare state (Giddens, 1999). Particular to crime control, risk has become institutionalised and individuals who pose the most risk to the majority have increasingly been defined as *the dangerous*. The injurious effects of this have potential to be enduring; yet assumptions are typically based upon subjective judgments. McGuire (2004 cited in Hewitt, 2008, p. 187) raises concern that 'socially constructed facts and conceptual uncertainties, which inform public perception of risk, may correspond only loosely to the threats posed in reality'. The presence of risk requires individuals and society's institutions

to risk manage their actions and therefore a risk aversion mentality becomes enshrined in the legislative/policy structure that governs society.

Control of situations or individuals that threaten the social milieu is undertaken systematically and as Lyon (2001) suggests, by virtue, a risk society is a surveillance society. Crime and danger are central to how risk may be conceived or understood; however it is only with a knowledge of the extent of crime, for example, that the true extent of the risk can be contemplated. Fear of crime is influential in the shaping of policy, legislation and public opinion on this subject, indeed, Jupp, Davies and Francis (2003, p. 144) suggest that 'there was no fear of crime in Britain until it was discovered in 1982' following innovations in publicly accessible crime surveys. Through these processes of attention and social and political reaction, particular types of offender, for example, the sex offender, violent offender and the mentally disordered offender occupy a particular position in the social psyche in which they are typified in a hierarchy of those who have a propensity to cause the most devastating and long-lasting harm or injury. The measures put in place to insure against these potential threats, and the news reporting of them shape their construction and identity and they become a 'major source of fear and anxiety' (Greer, 2003, p. 1).

Pre-occupation with the avoidance of harm therefore becomes impressed upon the lives of all citizens and the risk estimations serve to make the 'future become ever more absorbing, but at the same time opaque' (Giddens, 1999, p. 4). For the state, surveillance and control hold the key to circumnavigating social threats, however, as Rose (1998, p. 179) notes, 'the task for psychiatric professionals is now less therapeutic than administrative: administering problematic persons on a complex terrain in an attempt to control their future conduct'.

Systems of monitoring and control of the psychiatric patient in the less-restrictive context of the community have had a problematic history. The removal of the physical or material systems of control (for example the hospital building) in favour of pharmaceutical control and visitations (for example, depot injections and community-based practitioners), psychiatry and politics have experienced the uncomfortable apologies of responding to society where things have gone wrong. The rhetoric association of dangerousness, risk and mental disorder has advanced at a significant pace, not least during the early 1990s. The murder of Jonathan Zito at a tube station in London in December 1992 by Christopher Clunis sparked fury and opened the debate on the abilities of health and allied services to manage those diagnosed with mental disorder in the community. This tragedy was marked by systematic failures in the continuity and supervision of Clunis, having contact with over thirty psychiatrists and ten inpatient episodes for the assessment and treatment of a psychotic illness prior to Zito's murder (Coid, 1994). A report into the circumstances surrounding these events concluded that opportunities had been missed by health professionals (Ritchie, Dick and Lingham, 1994) and called for revised and robust measures for supervision in the community.

Parliamentary responses to the perceived crisis of dangerousness in society amounted to a rapid addition to the MHA (1983). Section 25a MHA (1983) 'Supervised Discharge' was introduced under the Mental Health Act (Patients in the Community) (1995) in a move to counteract Health Secretary Frank Dobson's concerns that 'too many vulnerable patients were being left to cope on their own, creating a danger to themselves and the public' (Dobson, 1998 cited in Warden, 1998, p. 1611). The public protection agenda became centre stage with a number of calls to adopt a process of re-institutionalisation. By this time, risk and dangerousness was firmly aligned with the diagnosis of mental disorder, and catastrophic failures in supervision had a 'profound effect on public confidence in mental health services' (Burns and Priebe, 1999, p. 191), overshadowing the medical advancements of this era.

### *Risk Mitigation and Mental Health Policy*

With its origins in the nineteenth century, Mental Health Act legislation has seen several revisions, the latest being enacted in 2007. Monitoring of psychiatric treatment has been undertaken in a variety of formats for a number of centuries, such as parliamentary commissions and independent agencies. The Mental Health Act Commission was established under the Mental Health Act 1983, and recently this commission has become assimilated into a broader agency known as the Care Quality Commission (CQC). The CQC functions to evaluate how care and treatment is delivered set against governmental policies. They make routine and unannounced inspections and engage with service users to determine the quality of care being provided.

In the context of mental health care, the CQC has already begun to synthesise findings over the recently revised Mental Health Act in 2007. The CQC report 'Monitoring the use of the Mental Health Act in 2009/10' has unveiled a number of fundamental issues and concerns over the recently amended Mental Health Act (MHA). During this twelve-month review, the CQC has observed that the MHA has been used more than it ever has been before. The CQC (2010, p. 8) reports that 'over the last decade, there has been a steady decline in the overall number of people treated as inpatients in mental health hospitals'. Despite this however, the number of people detained under the MHA has remained at around 45,000 people per annum (In 2009/10 there were 45,755 detentions). Furthermore, the CQC (2010) draws attention towards an increase in the number of detained service users residing in low secure care environments.

These statistics apply to both National Health Service (NHS) and private sector treatment environments. Disturbingly, and in addition to the figures presented above, the CQC reports feedback from patients that 'hospital life is becoming much more focused on rules and security' (CQC, 2010, p. 11) with particular reference to locked inpatient mental health wards catering for both informal and detained service users. The CQC findings also raise concern outside of the boundaries of institutional care. Caution has further been raised over the introduction of the Community Treatment Order (CTO) and has been identified as providing opportunity for a broad use of coercive power (CQC, 2010). These findings are perhaps unsurprising for some in light of recent developments in the national field of mental health. This discipline has undergone radical shifts in policy, economic investment and legislation and is likely to see further major reforms into the second decade of the twenty-first century under developing government proposals.

Receiving Crown assent in 2007, the new Mental Health Act illustrates a considerable revisionist approach to psychiatry's compulsory powers. Capacity, autonomy and the role of compulsion in the assessment and treatment of the individual have been just some of the areas attracting critical debate. The Richardson Committee and later the Richardson Report (Department of Health, 1999a) undertook an evaluation of the reforms necessary to develop modernised mental health legislation. In its analysis, the Richardson Report (1999a, p. 6) remarked that 'the Committee is convinced that the notion of capacity has an independent value and meaning the core of which is accepted by all those involved in the operation of mental health legislation'. For the Richardson Committee, a focus on the individual's capacity to consent to treatment is indicative of an attention towards the best interests of the person. Further, placing capacity at the heart of legislation would, it was hoped, regulate the boundaries of compulsory admission and treatment. The Government's consultation paper based on the Richardson Committee's recommendations published the following concerns over its own expert panel's comments:

The principal concern about this approach [Richardson Report's recommendation on capacity as a central component of legislation] is that it introduces a notion of capacity, which, in practice, *may not be relevant* to the final decision on whether a patient should be

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made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity – while still relevant to the plan of care and treatment – may be largely irrelevant to the question of whether or not a compulsory order should be made.

(Department of Health, 1999b, p. 32, emphasis added)

As Zigmond (2001) explains, such analyses of risk rather than capacity taints decisions that are made surrounding compulsion under the Act, specifically that these decisions are not necessarily medical ones, rather they are prescriptive demands on risk minimisation amounting to a 'Public Protection Order'.

The most recent Mental Health Act has also incorporated two overarching changes; an abolition of the four categories of mental disorder in favour of a broader definition of mental disorder and, a test of 'appropriate medical treatment' being available introduced. It is this second aspect that has raised some concerns within academic and professional circles. The MHA 1983 made the clinician undertaking the Mental Health Act assessment responsible for evaluating whether the mental health condition was treatable. If so, and the individual was unwilling to enter hospital informally, then compulsion could be used. Within the MHA 2007, this 'treatability test' has been replaced with a statement that allows for the use of compulsion under the Act conditional that there is 'appropriate treatment available'. Although a small alteration, this has led to concerns that compulsion may be over-used as the threshold for detention has now been substantially lowered.

Such amendments and a lowering of compulsion thresholds may have the potential to increase hospital occupancy in line with cultural understandings of what constitutes a risky individual or the fear of blame being asserted should the wrong decision be made. A case that has featured as an area of significant deliberation is that of the diagnosis of personality disorder (PD). Compulsory hospitalisation of individuals suffering with a PD, a diagnosis first included under MHA 1959, has raised some disquiet from within professional groups over the legitimacy of detention, questioning the ability of the psychiatric profession to provide adequate treatment for this particular condition (see Sarkar, 2002) for an overview of the literature). Without some level of common agreement within the psychiatric profession on the ability to treat PD (and therefore whether they have capacity to consent to treatment or not) the situation remains problematic. Attention to risk, ambiguity and disagreement over treatability, and the perception of a lowered compulsion threshold have been regarded, by some, as components of a piece of legislation that is profoundly paternalistic, authoritarian and stigmatizing (Mental Health Alliance, 2007). As Prins (2008, p. 84) posits there is an 'over-emphasis on the use of the law in changing behaviour' and through amendments to the MHA, many more people may be subject to its sanctions and capabilities.

### *Regulating Meaning: The 'New' Dangerousness*

Institutions in society, such as the medical profession have been considered to have the capability to represent and regulate meaning (Cohen, 1985). Apprehension has been raised about the possible consequences of this, not least where these meanings pertain to those who may threaten the social milieu. Criminal justice and psychiatry may be observed to be implicit in this process, and theorists draw attention towards the widening of a net of control (Cohen, 1985). Examples of this concept in practice can be detected in criminal justice policy where penal populism has been seen to take an effective hold with the promotion of legislation and policy which are electorally attractive, but unfair, ineffective or at odds with a true reading of public opinion (Bottoms, 1995). Elsewhere, psychiatry has attracted similar criticism for its newly adopted broad definition of mental disorder,

removal of a treatability test and introduction of community treatment orders under the new MHA (Prins, 2008; Mental Health Alliance, 2007).

Failures in the supervision of patients and offender-patients in the community during the last decade of the twentieth century have galvanised new methodologies for the management of risk in the community. This was not something particular to psychiatry, but rather an approach mirrored by others involved under the rubric of public safety and crime control. The risk management agenda in criminal justice had adopted intolerance to liberal measures of managing offenders. The Criminal Justice Act (2003) represented a move towards the use of a prediction and estimation, becoming central to how the offender was processed by the criminal justice system. The introduction of indeterminate sentences for public protection (IPP) and the formalising of multi-agency public protection arrangements (MAPPA) under this piece of legislation embedded a cautionary principle in the management of those defined as 'dangerous offenders' (s.224-236 CJA, 2003). Despite the arbitrary and multiple meanings of the term 'dangerousness', its usage has become implicit in recent legislation such as s.229 of the CJA (2003):

*s.229 The assessment of dangerousness*

(1) This section applies where –

- (a) a person has been convicted of a specified offence, and
- (b) it falls to a court to assess under any of sections 225 to 228 whether there is a significant risk to members of the public of serious harm occasioned by the commission by him of further such offences.

(Criminal Justice Act 2003)

The rhetoric of risk and dangerousness now pervades boundaries of criminal justice and mental health policy with annual summaries such as the National Confidential Inquiry into Suicide and Homicide providing illustrations of the extent of this issue. Sixty-five convictions for homicide were recorded in 2006 perpetrated by individuals who had received psychiatric treatment in the twelve months prior to the offence (against a total of 539 homicides in the general population) (Appleby, Kapur and Shaw, 2010). Such statistical evidence raises a number of questions within professional circles as to how these figures can be reduced and what methods can be adopted to achieve it.

Statute law, empirical evidence and the developing remit of 'control professions' reinforce these new sensibilities surrounding risk and dangerousness, however new definitions present significant problems in negotiating balance between individual liberty and security. The prevailing discourses of security, protection and risk management have generated an anxiety over a number of decades. The 'anti' and 'critical' psychiatry movements have raised concern that such systems provide opportunities for some individuals (for example, professionals) to self-actualise whilst life chances of others (patients) are restricted (Castel, 1991). It has been widely theorised that psychiatry itself has fought to construct its own integrity at the cost of those subject to it (Foucault, 1967; Scull, 1979) whilst others have gone further to suggest that mental illness is socially constructed and used to categorise those who deviate from the dominant norms of society (Szasz, 1961).

Whilst the process of planning reforms for the MHA was being undertaken, simultaneously, revisions were being made to address further risk posed by the mentally disordered. During the late 1990s, proposals were being drawn up to accommodate what was to be defined as a new kind of 'dangerous offender'. These New Labour proposals were illustrative of a politics with a priority on public protection. The brutal murder of Dr Lin Russell and her six-year old daughter Megan, and attempted murder of nine-year old Josie by Michael Stone in July 1996 provided a significant bolstering to these new proposals. It had emerged that prior to the murders, Stone had been detained for assessment under the MHA (1983) and had been diagnosed with a personality disorder. However he was

assessed as having mental capacity and subsequently released from hospital. As Rutherford (2006, p. 55) explains, 'the authors of these new proposals accepted that the status quo was unacceptable'. Public safety appeared to be in jeopardy from a preying risk of individuals who had slipped through the net of criminal justice and health agencies. The Dangerous Severe Personality Disorder (DSPD) proposals of the early late 1990s were viewed as a remedy to such heinous crimes being perpetrated in the future.

Cultivating a new MHA that would support DSPD proposals was problematic and remained an area of contention, not least in the concerns of the ability to treat this condition, with some asserting that a personality disorder is very different from a mental illness because 'it is essentially a developmental disorder' (Eastman, 2000 cited in Seddon, 2008, p. 29). Over the course of ten years, the DSPD programme evolved and amounted to around three hundred beds across four units (two based in prisons and two based in High Secure Hospitals) that accommodate those risk assessed and assimilated into this category. As Rutherford (2006) indicates, DSPD proposals have become illustrative of a leading example of a much wider change in criminal justice agendas.

Evaluative analysis by Tyrer et al (2010) of the DSPD programme has been largely inconclusive in terms of establishing clear programme successes to support future economic investment in this initiative or its ethical base. This review of the programme draws attention towards the heavy financial implications associated with detaining individuals in this way and also the questionable practices where 'many prisoners are moved into the DSPD programme very close to the time at which their sentence tariff is about to end' (Tyrer, et al, 2010, p. 97). Scepticism over the cost effectiveness of the DSPD programme has most recently been seen in the Response to the Offender Personality Disorder Consultation (Department of Health, 2011) whereby the UK government plans to decommission the NHS DSPD units and to re-shape the services, interventions and treatments for offenders with severe personality disorder (SPD) within the prison estate.

As an example, the DSPD programme and the developed attention towards personality disorder highlight a favouring of psychiatry to remedy forms of social deviance and a degree of therapeutic optimism in how identified conditions can be addressed. However, they also examples illustrate the tenuous balance between security and liberty. The aura of risky populations has become the zeitgeist. As a society, and through the structural and administrative responses implemented by politics and the state, England and Wales are fearful of risk itself. Whilst the imagery of Brady and Sutcliffe were once the faces of the dangerous offender with mental disorder, these have been replaced by the facelessness of interventions and resurgence in purpose-built facilities of containment.

### *Control Beyond Incarceration*

The CQC (2010) reports that, in a relatively short period of time, reformed legislation appears to have given way to greater use of coercive (formal treatment under the MHA) mental health treatment. Whilst a wholesale return to Victorian asylumism (Scull, 1993; Morrall and Hazelton, 2000) may not be evident, regimes of security, actuarial discourses, incapacitation and arguably 'warehousing' are pronounced and evident in modern psychiatry (O'Malley, 2004). Psychiatry has long operated its own systems of bifurcation (Cohen, 1985). Ranging from community supervision to hospitalisation, the current tendency appears to favour institutionalisation as the preferred methodology, most noticeable in an expansion in formally detained inpatients, a growth in low secure provision (CQC, 2010). In common with crime control agendas, psychiatry has become increasingly involved as a defensive agent (Hotopf *et al.*, 2000) and implicit in the security and risk discourses that pervade society.

Whilst formal hospitalisation may be on the increase, community supervision has also received legislative attention through revisions to the MHA. Supervised Community

Treatment (SCT) has been emphasised with the introduction of the Community Treatment Order (CTO), a replacement of s.25a–25j (supervised discharge) of the MHA (1983). The CTO provides authority to the responsible clinician to recall a patient back to hospital subject to them being liable to be detained under s.3 of the MHA. These measures are viewed by the profession as a competent method to reduce the likelihood of deterioration in the mental wellbeing of an individual by minimising the risk of harm to themselves or others through swift hospitalisation (Mind, 2011).

However, much like other amendments contained in the revised MHA, the introduction of the CTO has sparked controversy. Speaking in the House of Lords debates in 2007, Conservative Shadow Minister for Health Earl Howe raised his concerns about the consequences of the CTO being enacted. Drawing from concerns already raised by the Mental Health Act Commission, Howe referred to the addition of the CTO in MHA legislation as the introduction of the ‘psychiatric ASBO’ (Howe, 2007). Despite these frustrations and concerns with plans contained within the Mental Health Bill (2006) to validate more stringent community supervision, the CTO has maintained its position on statute and has become an increasingly used addition to psychiatry’s repertoire of sanctions.

In the first full year of the revised MHA, in England 4,107 CTOs were made (CQC, 2010, p. 96). Despite this, the efficacy of the CTO has come under scrutiny in a review of their usage internationally. A Cochrane Review of CTOs established that where used, compulsory community treatment offered ‘no significant difference in health service use, social functioning or quality of life compared with standard care’ (Kisely, Campbell and Preston, 2011, p. 2). Whilst the efficacy of the CTO is being challenged, the CQC has also explored how they are used. In a review of 208 reports analysed by the CQC (2010) three alarming themes emerged. Firstly, one third of the sample was receiving medication for their mental health condition above the advisory limits of the British National Formulary. Secondly, whilst the CQC note the difficulties of obtaining accurate statistical data in this area, they report that in the sample analysed, there was evidence of a disproportionate use of the CTO amongst black and ethnic minority groups. Lastly, the CQC report that one third of their sample placed on a CTO has no reported history of non-compliance or disengagement with treatment.

Given the data presented by the CQC, the legitimacy of the use of the CTO is questionable. The veil of risk prevention, actuarial practices and surveillance has emerged from the radical revisionist approach to mental health law. Psychiatry has re-established and intensified its position as a key agent in the control and regulation of the meaning of risk and dangerousness. Failures in supervision of the past haunt policies of the present where ‘the reality is that community care is a makeshift policy of competing pressures for control’ (McCann, 1998, p. 60). Whilst such policies and interventions may address human suffering and limit the potential for harm, as is evident from this CQC report, it is only now that some indication is available of the broad approaches and coercive powers of a discipline that is professionally somewhat distanced from the criminal justice system, yet has an equal ability to apply an array of sanctions legitimised through its self-regulating authority over the right to treat the treatable and attempt to treat the untreatable.

### *Conclusions*

The revisions to the MHA and associated policy and programme developments in the field of psychiatry have developed a situation of a systematic growth in diagnosis and detention. Social deviance is increasingly becoming medicalised and psychiatry is required to engage with a broader mandate. Medical paternalism has a firm hold and assessment and treatment are not solely located within the ambition to treat; rather psychiatry must adhere to broader approaches to the social deviant and prevailing discourses of risk management and physical controls. The modern psychiatric treatment environment has therefore become



part of a broad 'expurgatory system' (Mathiesen, 2006, p. 141) designed to provide accommodation and arrangements for those in society who are problematised or diagnosed. Diagnosis is therefore a tool and as such any person who is diagnosed is subject to further assessment in terms of risk discourses and in some cases may identify them as unmanageable. In such cases further systems to ensure public safety are imposed in a bid to provide insurances against potential breaches of wider society's security (Corbett and Westwood, 2005).

The encompassing framework of psychiatry, diagnosis and the removal of a treatability test in the new MHA provide, in the view of some, a panacea for the regulation of society. They are symbolic of new strategies for crime control and social obedience. Arguably psychiatry has become an agent or tool of crime control, more so than being strictly a rehabilitative endeavour. Risk has become institutionalised within governing agencies and disciplines but has also been internalised by society's citizens. The MHA (2007) and CJA (2003) both serve to illustrate conceptually similar objectives despite emerging from ideologically opposed worlds (therapy versus punishment). In response to the prevalence of risk discourses, governments see the need to 'qualify their claim to be the primary and effective provider of security and crime control' (Garland, 1996, p. 449). Such an achievement is problematised by high profile failures and harm perpetrated by a minority. However, a predicament emerges, where new categorizations and new aggregated identities of the dangerous shape the sensibilities of policies to control them and the general public who are supposedly protected by the sanctions imposed.

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